3500. INTRODUCTION

This chapter describes the categorically needy groups which you may include under your plan. Eligibility under these groups is related to the Aid to Families with Dependent Children (AFDC) Program or the Supplemental Security Income (SSI) Program.

3500.1 Changes Due To Welfare Reform.--The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC program and replaced it with a block grant program for temporary assistance for needy families (TANF). This elimination of the AFDC program is effective (by State) on July 1, 1997 or the date on which the Secretary of Health and Human Services (the Secretary) receives the TANF State plan, if earlier. After the AFDC State program has been terminated, all references to AFDC (or title IV-A) in this chapter are references to AFDC under the AFDC State plan in effect on July 16, 1996.

Less restrictive income and resource methodologies adopted under §3301.1G are not carried over to the references to AFDC in this chapter. All references to AFDC in this chapter include only the income and resource methodologies under your AFDC State plan in effect on July 16, 1996.

3500.2 Self-Implementing Groups.--Policies set forth in this chapter are self-implementing. The policies are based on the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-748), the Deficit Reduction Act (DRA) of 1984 (P.L. 98-369), the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P. L. 99-272), the Omnibus Budget Reconciliation Act (OBRA) of 1986 (P. L. 99-509), the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P. L.100-203), the Medicare Catastrophic Coverage Act (MCCA) (P. L. 100-360), the Family Support Act (FSA) of 1988 (P. L. 100-485), and the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239).

Sections 1902(a)(10)(A)(ii), 1902(a)(47), 1902(e), 1902(l), 1902(m), and 1920 of the Act provide the legal basis for the following optional groups:

- Persons who meet the income and resource requirements for, but do not receive, cash assistance (i.e., AFDC, SSI, or an optional State supplement (OSS).) (See §§1902(a)(10)(A)(ii)(I)) and 1905(a) of the Act.)

- Children under 21 (or reasonable classifications of such children) who meet the income and resource requirements for payment under AFDC. (See §1902(a)(10)(A)(I)(I) of the Act.)

- Persons who (but for work-related child care costs being paid by a State agency as a service expenditure) meet AFDC income and resource requirements. (See §1902(a)(10)(A)(ii)(II) of the Act.)

- Enrollees of qualified health maintenance organizations (HMOs) who no longer meet income and resource requirements for payment under AFDC. (See §1902(e)(2) of the Act.)

- Children under States' (or territories') adoption assistance programs who have special medical or rehabilitative needs. (See §1902(a)(10)(A)(ii)(VIII) of the Act.)

- Persons who would be eligible to receive AFDC if a State's AFDC plan were as broad as allowed under the AFDC statute. (See §1902(a)(10)(A)(ii)(III)of the Act.)

- Persons who do not receive SSI, but who are eligible for or who do receive an OSS. (See §1902(a)(10)(A)(IV) of the Act.)

o Pregnant women and infants who have income that is above 133 percent of the Federal poverty levels and under your established levels that do not exceed 185 percent of the Federal poverty levels. (See §§1902(a)(10)(A)(ii)(ix) and 1902(l) of the Act.)

o Children born after September 30, 1983, who have attained age 6 but have not attained 7 or 8 years of age (as chosen by you), and who have income under your established levels that do not exceed 100 percent of the Federal poverty levels. (See §§1902(a)(10)(A)(ii)(ix) and 1902(l) of the Act.)

o Aged and disabled persons who have income under your established income levels that do not exceed 100 percent of the Federal nonfarm poverty level. (See §1902(a)(10)(A)(ii)(X) of the Act.)

o Pregnant women determined eligible for ambulatory prenatal care under presumptive criteria. (See §§1902(a)(47) and 1920 of the Act.)

o Persons in medical and remedial care institutions who:

- Are OSS recipients;

- Are eligible for, but are not receiving AFDC, SSI, or an OSS; or

- If not in an institution, would be eligible to receive AFDC, SSI, or an OSS. (See §1902(a)(10)(A)(ii)(IV) of the Act.)

o Persons in medical and remedial care institutions who are eligible under a State established income level. (See §1902(a)(10)(A)(ii)(V) of the Act.)

o Persons receiving services under an approved home and community-based waiver. (See §1902(a)(10)(A)(ii)(VI) of the Act.)

o Persons who are terminally ill and who are voluntarily receiving hospice services rather than institutional services. (See §1902 (a)(10)(A)(ii)(VII) of the Act.)

o Disabled children age 18 and under who, if in a medical institution, are Medicaid eligible. (See §1902(e)(3) of the Act.)

o Recipients of optional State supplements in States without Federally administered State supplements and without §§1634 or 1616 agreements. (See §1902(a)(10)(A)(ii)(XI) of the Act.)

3501. DEFINITIONS

The following definitions are to be used for this chapter:

o Aged - persons age 65 and older;

o Blind - persons who meet the SSI definition of blindness under §1614(a)(2) or a more restrictive definition approved under §1902(f) of the Act (whichever is applicable);

o Disabled - persons who meet the SSI definition of disability under §1614(a)(3)(A) or a more restrictive definition approved under §1902(f) of the Act (whichever is applicable);

o Caretaker Relatives - relatives specified in §406(b)(1) of the Act with whom a child is living if the child could be classified as a dependent child under AFDC; and

o Pregnant Women - women whose pregnancy has been medically verified by a medical professional authorized under State law to make such determinations.

3502. PERSONS WHO MEET INCOME AND RESOURCE REQUIREMENTS FOR, BUT DO NOT RECEIVE CASH ASSISTANCE

You may include under your plan any one or more of the following who meet the income and resource requirements to receive AFDC, SSI, or an OSS (whichever is appropriate):

- o Aged;
- o Blind;
- o Disabled;
- o Caretaker Relatives; and/or
- o Pregnant Women.

3502.1 Aged, Blind, and Disabled.--Use SSI or OSS income and resource requirements (whichever is applicable).

If you elect not to include under your plan all recipients of SSI, but elect to use more restrictive eligibility requirements for the aged, blind, and disabled, you cannot elect to include the aged, blind, and disabled in this eligibility group. This is because SSI policies in their entirety are not used to determine eligibility for this group in your State as you have elected to use more restrictive eligibility rules for these types of individuals.

3502.2 Caretaker Relatives.--Use AFDC program policies at §§406(a), 406(b), and 407(a) of the Act to determine if a relative is included under this group. Section 406(b) includes requirements relatives must meet and §§406(a) and 407(a) include criteria for determining if children living with such relatives are dependent.

Use all AFDC income and resource requirements including application of income to all AFDC income standards. Unless otherwise specified, include the needs, income and resources of persons whose needs, income and resources would be included in an AFDC determination (including those of siblings under age 18 (or 19) who are living in the home).

3502.3 Pregnant Women.--Use AFDC income and resource requirements including application of income to all AFDC income standards. Unless otherwise specified, include the needs, income and resources of pregnant women, any children under 21 who are living in the home, and unborn children's fathers who are living in the home.

3502.4 Retroactive Medicaid Coverage.--

A. General.--You are required (for purposes of establishing an effective date of eligibility) to determine if applicants who have unpaid bills during the three calendar months prior to the month of application would have been eligible under your plan during that prior period had they applied for Medicaid.

B. Change in Month of Receipt of SSI.--Public Law 104-193 requires that SSI payments generally may only begin as of the first day of the month following (1) the date the application is filed or if later, (2) the date the person first meets all eligibility factors. This change in the law creates a delay of one month (the month of application for SSI) during which an individual whose only basis for Medicaid eligibility is actual receipt of SSI benefits is not eligible for Medicaid. This delay has sometimes been referred to as a "gap". (Certain individuals may receive emergency advance SSI payments, which could mitigate the delay.)

If you have an optional or mandatory eligibility group under which these individuals can be covered by Medicaid in the "gap" month, such as the optional group of persons who meet SSI income and resource requirements, you must provide Medicaid to these individuals for the "gap" month in which no SSI payment is made. You must also provide up to three months retroactive coverage for those months in the retroactive period for which the person had incurred medical expenses and met the eligibility requirements of the group.

Section 1902(a)(34) of the Social Security Act requires you to provide retroactive eligibility during the period beginning with the third month prior to the month of application for Medicaid, "if such individual was (or upon application) would have been eligible" for Medicaid at the time care and services were furnished. This provision clearly presumes that you will assume that the individual applied for Medicaid for purposes of determining whether he/she would have been eligible during the retroactive period.

However, it is not clear whether it also requires you to presume that he/she filed an application for SSI and further assume that SSI benefits would have been paid in any months in that period had he/she met the requirements of the SSI program. HCFA previously only permitted you to assume that the individual applied for Medicaid, in determining eligibility for the retroactive period, not that the individual applied for and would have received SSI.

Because of the change in the effective date for SSI payments, HCFA has reexamined this position. HCFA now believes that you have the choice in interpreting §1902(a)(34) of the Act. You may choose to continue to read it as only presuming that the individual applied for Medicaid in the retroactive period, or you may read it to presume that he/she applied for Medicaid and SSI and that SSI would have been paid pursuant to that application (if he/she met the SSI eligibility criteria).

If you adopt the latter interpretation of §1902(a)(34) of the Act, you will be able to provide retroactive Medicaid beginning with the second month prior to the month in which the individual applied for Medicaid and ending with the date in which his/her prospective eligibility begins based upon receipt of SSI. You will be able to provide this eligibility even though you do not have an eligibility group covering individuals who are eligible for SSI payments but do not receive them. This eligibility would be based on your determination that the individual would have received an SSI benefit if he/she had applied in the retroactive months. Such a determination will lessen the delay in Medicaid eligibility caused by the change in the law regarding the effective date of actual receipt of SSI benefits. Under this policy, you can provide Medicaid eligibility in this situation for the month prior to the first month of actual SSI payment and the two preceding months if the individual meets all Medicaid eligibility requirements in those months.

These individuals will not be eligible for Medicaid in the third month prior to the month in which they applied for Medicaid and SSI (the first month of the retroactive period) since SSI would not have made a payment in this month.

3503. CHILDREN UNDER AGE 21

You may include under your plan all (or reasonable classifications of) children under age 18, 19, 20, or 21 who meet the income and resource requirements for payment under your AFDC or title IV-E plan (whichever is appropriate).

If you choose to include in your plan all children under a specified age, you cannot restrict the living arrangements of the children. For example, you cannot require the children to live with relatives of some specified degree of relationship or some other adult. You must include children living independently.

3503.1 Age Limits.--You may limit eligibility at any age between 18 and 21. You may not, however, use an age limit lower than 18.

Normally, you cannot use an age restriction that is not used for all children in the group. There is, however, an exception in the case of children between ages 18 and 19. You may limit eligibility to children between 18 and 19 to children who are full-time students reasonably expected to complete a program of secondary school education or the equivalent level of vocational or technical training before reaching age 19 because these are the conditions under which AFDC is extended to children between age 18 and 19.

3503.2 Reasonable Classifications.--42 CFR 435.222 sets forth the following examples of reasonable classifications. You are not limited to these classifications, but classifications must be reasonable as determined by the Secretary of the Department of Health and Human Services.

- Children in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility. If you include such children in your plan, you may also include children placed by private non-profit agencies in foster homes and/or private institutions.

- Adopted children subsidized in full or part by public agencies.

o Children in intermediate care facilities when such facility services are included in your plan. If you include children in intermediate care facilities (ICF), you may also include children in intermediate care facilities for the mentally retarded (ICF-MR) if you include such services in your plan.

o Children under 21 receiving active treatment as inpatients in psychiatric facilities or programs when such services are provided in your plan to children under 21.

Although not included in 42 CFR 435.222, it is not unreasonable to require that children under this election meet AFDC deprivation requirements. This limitation has the effect of providing Medicaid to children who are eligible for AFDC, but are not receiving such benefits.

3503.3 Financial Eligibility.--Unless you have in your approved plan more liberal methods approved under §1902(r)(2) of the Act, use AFDC income and resource requirements including application of income to all AFDC income standards. Unless otherwise specified, include the needs, income and resources of persons whose needs, income and resources would be included in an AFDC determination (including those of siblings under age 18 or 19 living in the home) and any siblings under age 21 included under your plan as AFDC related. Included as income in these determinations are AFDC payments received by any members of the Medicaid budgetary unit. For example, when a parent and siblings under age 18 receive AFDC and a sibling age 20 is applying for Medicaid under this eligibility group, the members of the AFDC unit are included in the 20 year old's budgetary unit. Therefore, the income (including the AFDC payment) and the resources of these family members are used to determine eligibility of the 20 year old sibling.

Use title IV-E income and resource requirements for children who are not temporarily absent from their family settings, but are living in foster homes or medical or non-medical institutions because title IV-E policies address situations where children are living apart from their parents. (The AFDC program only addresses situations where a child or parent is temporarily absent from the usual family setting.) The title IV-E criteria used are those which the title IV-E program uses to determine payment for children in foster care (i.e., only a child's income and resources and actual contributions from parents are used in these calculations).

3504. Reserved

3505. Reserved

3506. CHILDREN UNDER STATE ADOPTION ASSISTANCE PROGRAMS

You may include under your plan children under age 18, 19, 20, or 21 for whom there are legally executed adoption agreements (other than title VI-E agreements) between your State (or territory) and adoptive parents when you determine that:

o such children have preexisting special medical and rehabilitative needs;

o adoption placement for such children is precluded if services under your plan are not provided; and

o such children (prior to or at the time of execution of adoption agreements) were:

- receiving or eligible to receive Medicaid under your plan regardless of the eligibility group (i.e., as optional or mandatory categorically needy or medically needy) or whether initial eligibility was established in the three month retroactive period prior to application); or

- (at your option) would have been eligible under your plan if certain title IV-E foster care income and resource requirements had been used to determine eligibility rather than other plan requirements.

Once initial eligibility has been established, that determination is binding as long as an adoption agreement is in force and the child is within the age limitation.

3506.1 Special Medical and Rehabilitative Needs.--Children must have at the time of the execution of an adoption agreement an existing medical or rehabilitative need. Thus, children who develop a special need after such agreements are executed are not eligible under this eligibility group. For example, a child who develops a condition which requires medical or rehabilitative care even 1 day after execution of an agreement is not eligible.

3506.2 Financial Eligibility.--You may use AFDC financial requirements or certain title IV-E requirements to determine eligibility. The title IV-E criteria you may use are those which the title IV-E program uses to determine payment for children in foster care (i.e., only a child's income and resources are used to determine eligibility.) AFDC requirements include the counting of adoptive parents income and resources as well as those of adoptive children.

3506.3 The Relationship of Children Described in This Section and §3503.--You may include children in subsidized adoptions in the two eligibility groups. There are, however, differences in the two groups. Children in subsidized adoptions are considered a reasonable classification of children under 21 under the provisions of 42 CFR 435.222. Children in the 42 CFR 435.222 group described at §3503 do not have to have a special medical or rehabilitive needs nor must they have been in recipient status at the time the adoption assistance agreements were signed. Additionally, under the §3503 group, you do not have the option to use title IV-E foster care payment criteria to determine financial eligibility nor are you exempt from considering changes in circumstances that can affect eligibility.

3506.4 Special Provisions for Adoption Agreements Entered Into Prior To April 7,1986.--Children under legally executed adoption assistance agreements entered into prior to April 7,1986 are eligible if you determine that:

o at the time of adoption placement such children had special medical and rehabilitative needs that made the child difficult to place; and

o for such children, there is an adoption assistance agreement between the State and the adoptive parent(s); and

o prior to entering into the agreement (other than an agreement under IV-E) such children were found eligible under your plan.

3570 OPTIONAL PRESUMPTIVE ELIGIBILITY PERIOD FOR PREGNANT WOMEN

A. General Policy.--You have the option to provide ambulatory prenatal care to pregnant women during a single limited period of presumptive eligibility. The period of presumptive eligibility begins on the day a pregnant woman is determined presumptively eligible. If a presumptively eligible woman files a Medicaid application by the last day of the month following the month in which she is determined presumptively eligible, she remains presumptively eligible until a determination is made on that application. If a presumptively eligible woman does not file an application for Medicaid by the last day of the month following the month in which she is determined presumptively eligible, her presumptive eligibility ends on that last day.

Presumptive eligibility must be determined by a qualified provider.

A woman is presumptively eligible if she is pregnant and if a qualified provider determines, based on preliminary information, that her gross family income does not exceed the highest income standard under which she might be eligible (i.e., the higher of poverty level or medically needy standard).

After a woman is determined presumptively eligible by a qualified provider, she may receive services from any provider that is eligible (subject to the requirements of §1903(i)(14) of the Act) for payment for services under your plan.

NOTE: FFP is available to you for payments made on behalf of a woman who is correctly determined to be presumptively eligible. If she does not file a Medicaid application, or files an application and is determined ineligible, payments made on her behalf for covered ambulatory prenatal care during the period of presumptive eligibility are not included in your total amount of erroneous excess payments.

B. Definition.--A qualified provider is a provider that:

o is eligible to receive payments under an approved State plan; and

o provides services of the type provided by: (1) outpatient hospitals (see §1905(a)(2)(A) of the Act); (2) rural health clinics under your plan (see §1905(a)(2)(B) of the Act); or (3) clinics furnished by, or under, the direction of a physician, without regard to whether the clinic itself is administered by a physician (see §1905(a)(9) of the Act); and

o has been designated by you, in writing, as a qualified provider on the basis of your determination that the provider is capable of making determinations of presumptive eligibility; and

o receives funds under one of the following:

-- the Migrant Health Centers, Community Health Centers, or Public Health Service primary care research and demonstration projects (see §§329, 330 and 340 of the Public Health Service Act); or

-- the Maternal and Child Health Services Block Grant Program (see Title V of the Act); or

-- Health Services for Urban Indians (see Title V of the Indian Health Care Improvement Act); or

o participates in a program established under:

-- the Special Supplemental Food Program for Women, Infants and Children (see §17 of the Child Nutrition Act of 1966); or

-- the Commodity Supplemental Food Program (see §4(a) of the Agriculture and Consumer Protection Act of 1973); or

o participates in a State perinatal program; or

o is itself the Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act.

NOTE: You may determine whether a program is a State perinatal program. In making this determination, take into account the overall intent of the presumptive eligibility provision as well as the nature and purpose of the program involved.

C. Responsibilities of a Qualified Provider.--A qualified provider must:

o make determinations of presumptive eligibility;

o notify you of any determination that a woman is presumptively eligible within 5 working days after the determination is made;

o provide Medicaid applications to pregnant women who are determined presumptively eligible or who wish to apply; and

o assist pregnant women in completing and filing their applications for Medicaid.

NOTE: You are required to provide application forms to qualified providers and to give them information on how to assist the pregnant women in completing and filing the forms.

If a woman is determined to be presumptively eligible, the qualified provider must inform the woman in writing, at the time the determination is made, that:

o if she does not file an application for Medicaid by the last day of the next month, her presumptive eligibility ends; and

o if she does file an application for Medicaid by the last day of the next month, her presumptive eligibility continues until a determination of her eligibility based on that application is made.

NOTE: The qualified provider need not inform the woman of the consequences of not filing an application for Medicaid if the provider knows that the woman has already completed such an application (e.g., if the same form is used to screen for presumptive eligibility and to apply for Medicaid.)

If a woman is determined not to be presumptively eligible, the qualified provider must inform the woman of the following, in writing:

o the reason for the determination; and

o that she may file an application for Medicaid if she wishes to have a formal determination; and

-- where she can apply for Medicaid; or

-- that she has not been determined presumptively eligible but that her application for Medicaid has been received and she will be informed later of the formal determination made on the basis of that application.

D. Forms.--You may use a single form as both a screening form for presumptive eligibility and as a regular application for Medicaid (including a shortened application used for low income pregnant women described in §1902(l)(1) whose eligibility is related to the poverty level). However, you may not require that a pregnant woman provide information on a combined form which is not needed to determine if she is presumptively eligible.

If you use a separate screening form and application, the application which the qualified provider gives to the pregnant woman may be your shortened application used to determine the eligibility of low income pregnant women described in §1902(l)(1) of the Act whose eligibility is related to the poverty level.

E. Notice and Appeal Rights.--

o If a presumptively eligible woman fails to file a regular Medicaid application, you do not need to take any action when her presumptively eligibility ends. In this case, the recipient was covered under a special time-limited status. Because she was never actually determined eligible for Medicaid, the notice and appeal rights of the Medicaid program do not apply.

o If a presumptively eligible woman files a regular Medicaid application, the standard notice and appeal rights apply.

3571. OPTIONAL COVERAGE FOR POOR PREGNANT (AND POSTPARTUM) WOMEN, INFANTS AND CHILDREN

At your option, you may provide benefits to certain low income pregnant (and postpartum) women, infants, and children born after September 30, 1983 who have attained age 6 but have not attained age 7 or 8 years of age and who do not qualify under a mandatory needy group.

To determine financial eligibility for pregnant women, newly eligibile women during the 60-day postpartum period and children, use an income standard determined in accordance with §3571.1A. In no case will this standard exceed 185 percent in the case of the women and infants or 100 percent in the case of the children.

The application of a resource test is optional. If you elect to apply a resource test, use a resource standard determined in accordance with §3571.1C.

You must maintain the eligibility of certain women throughout the 60 day post partum period and the remaining days of the month in which the 60th day falls. These are women who, while pregnant, applied for medical assistance and received services, and were eligible on the date the pregnancy ended.

NOTE: PAYMENTS WITH RESPECT TO ANY AMOUNT OF MEDICAL ASSISTANCE PROVIDED TO THIS OPTIONAL GROUP ARE NOT MADE TO YOU IF YOUR PAYMENT LEVELS IN EFFECT UNDER YOUR AFDC PLAN ARE REDUCED BELOW THE LEVEL IN EFFECT ON JULY 1, 1987.

3571.1 Financial Requirements.--

A. Income Standards.--Family income level must not exceed your set income level for the appropriate family size. In determining eligibility of the woman and the infant, the income level is no higher than 185 percent of the official income poverty level applicable for a family size equal to the size of the family, including the woman, infant, or child. The pregnant woman is budgeted as if her child were born and living with her at the time she applied for assistance.

In determining eligibility of children ages 6 or 7, the family income level must not exceed 100 percent of the official income poverty level.

The official income poverty level is determined by the Department of Health and Human Services and published in the Federal Register annually within 30 days after Consumer Price Index data are released.

B. Income Methodologies.--Family income must be determined in accordance with the methodology applied under the State AFDC or the State title IV-E adoption assistance or foster care plan, as appropriate. However, AFDC and title IV-E methods may be applied only to the extent that they are consistent with the statutory criteria of §1902(a)(17)(D) of the Act. That is, in determining eligibility of poverty level pregnant

women, infants and children, only income deemed from a parent to a child or from a spouse to a spouse is considered available and may be deemed to the assistance unit. Family income is income remaining after appropriate disregards are applied. Additionally, if you impose a premium as set out in §3571.5, and the premium is paid on behalf of the individual from State or local funds, the amount paid from State or local funds does not count as income to the individual.

Costs incurred for medical care or for any other type of remedial care is not taken into account in determining the family's income. That is, no spenddown is applied in determining eligibility of individuals under the poverty income guidelines. Individuals who do not meet the eligibility criteria for this optional categorically needy group must meet current medically needy eligibility criteria to establish eligibility as medically needy.

C. Resource Standards and Methodologies.--The application of a resource standard for the pregnant woman, infant, or child is at your option.

If you set a resource standard for pregnant women and women during the 60-90 day extended period, that standard and the methodology used to determine the value of her resources may be no more restrictive than that applied in the Supplemental Security Income Program.

If you set a resource standard for infants and children, that standard and the methodology applied to determine the value of the infant's or child's resources may be no more restrictive than that applied in your AFDC plan.

NOTE: If you establish resource standards for both the woman and an infant or child, you may need to perform two separate resource computations, since the woman's resources are determined in accordance with SSI methods and the infant or child's resources are determined in accordance with AFDC methods. As a result, you may count the same resources in each computation.

3571.2 Benefits.--

A. Pregnant Women.--Benefits to women eligible under the poverty income levels are limited to services related to pregnancy, including prenatal, delivery, post partum, and family planning services, and other conditions which may complicate pregnancy.

While specific services or conditions to be included are not listed, you are expected to reasonably interpret these statutory provisions to achieve a successful pregnancy outcome. Services included must be services which are coverable under §1905 of the Act.

B. Infants and Children.--Infants and children eligible under this new category are entitled to all services included in your plan.

3571.3 Postpartum Period.--A woman may become newly eligible during the 60 day period beginning on the last day of her pregnancy during which time she is considered part of the group of poverty level pregnant women.

You must provide services for 60 days post partum, and the remaining days of the month in which the 60th day falls, to all women who during pregnancy:

- o applied for medical assistance;
- o were eligible; and
- o received services.

3571.4 Mandatory Continuation of Assistance to Children.--If an infant's or child's eligibility ends because the maximum age with respect to which you provide coverage has been reached, but the child continues to meet all other eligibility criteria, and is receiving inpatient services provided under your plan on the date that eligibility should end, the child's eligibility continues until the end of his or her inpatient stay.

3571.5 Premium Option.--Section 4101(d) of OBRA 87 which amended §1916(c) of the Act authorizes you to impose premium payments on poor pregnant women and infants under age 1 whose family income equals or exceeds 150 percent of the Federal poverty income level.

A. General.--You may provide for imposing a monthly premium, not to exceed the limits set forth in subsection B, on a pregnant woman or infant under age 1 described in §1902(l) of the Act, who receives Medicaid on the basis of §1902(a)(10)(A)(ii)(IX) and whose family income equals or exceeds 150 percent of the Federal poverty income level. Family income is determined in accordance with §3571.1B.

The person responsible for payment of the premium for a minor is determined in accordance with State law.

B. Premium Limits.--In no case may the premium charged under this section be more than 10 percent of the amount by which family income (as determined in accordance with §3571.1B.) after deducting expenses for the care of dependent children, exceeds 150 percent of the Federal poverty income level. Since income eligibility of this optional categorically needy group (like the cash programs) must be determined on a monthly basis, the premium is also determined on a monthly basis. If you elect, to provide continuous eligibility without regard to changes in family income, determine income on a monthly basis in order to ensure conformance with the limits.

C. Prepayment Requirement Prohibited.--You may not require prepayment of the premium imposed under this section.

D. Termination for Nonpayment of Premium.--You may terminate the eligibility of the individual for nonpayment of the premium. However, you cannot terminate eligibility until the premium has been unpaid for a period of 60 calendar days from the date due. The termination action must be in compliance with the requirements in 42 CFR 431, Subpart E.

E. Waiver of Payment.--You may waive payment of a premium imposed under this section where you determine that requiring the payment would create an undue hardship. Undue hardship is determined in accordance with the guidelines in your approved State plan for waiver of the premium payment.

F. Use of State or Local Funds to Pay Premium.--You may use State or local funds available under other programs to pay for a premium imposed under this section.

The amount paid with State or local funds is not counted as income to the individual with respect to whom the payment is made.

G. State Plan Requirements.--The imposition of a premium under this section is authorized only under a State plan amendment approved by HCFA.

Include in your State plan the following information:

- a description of the method by which premium amounts are determined;

- a description of the billing method you employ, including the due date for the premium payment, notification of the consequences of nonpayment, and the waiver of payment procedure;

- a statement as to whether State or local funds under other than the Medicaid program are used to pay for premiums; and

- a definition of undue hardship for purposes of granting waivers under subsection E.

3580. HOSPICE BENEFITS - GENERAL ELIGIBILITY PROVISIONS

Section 9505 of Public Law 99-272 (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), enacted on April 7, 1986, amended title XIX of the Social Security Act (the Act) to permit hospice care benefits as defined under sections 1905(a)(18) and 1905(o) of the Act to be provided, at State option, to individuals eligible for Medicaid under the State plan, including those eligible under the optional hospice care eligibility group described in the following section. In order for individuals to receive hospice care they must be determined to be terminally ill (i.e., a medical prognosis has been made indicating a life expectancy of 6 months or less) and have voluntarily elected to receive hospice care in lieu of certain other benefits described in §1812(d)(2)(A) of the Act and intermediate care facility services under the plan.

3581. OPTIONAL HOSPICE CARE ELIGIBILITY GROUP

Section 9505(b)(2) of COBRA amended the Social Security Act to establish a new optional categorically needy eligibility group related to hospice care benefits for individuals not residing in medical institutions under section 1902(a)(10)(A)(ii)(VII). Eligibility under the optional group is determined using the same special institutional income standard that is used in determining eligibility for individuals in medical institutions.

Under section 1902(a)(10)(A)(ii)(V) of the Act and implementing regulations at 42 CFR 435.231, States, at their option, may determine eligibility for individuals actually living in medical institutions by use of a special income eligibility standard. This standard, for purposes of Federal financial participation, may be no higher than 300 percent of the amount payable to an individual living alone with no other income under the Supplemental Security Income (SSI) program.

Those States which include in their State plans the optional categorically needy group of individuals living in medical institutions under 42 CFR 435.231 may also choose to determine eligibility of terminally ill individuals who voluntarily elect hospice benefits and who are not living in a medical institution by application of the same special income standard as applied to the group under 42 CFR 435.231. States which do not include individuals under 42 CFR 435.231 in their State plans may not cover individuals electing hospice care under the special institutional standard.

Eligibility under the optional categorically needy hospice group is determined in accordance with State plan requirements by applying the financial and nonfinancial criteria including institutional deeming rules that would be applied if the individuals were actually living in a medical institution.

The optional hospice group may be comprised, at State option, of all or any of the following groups of individuals:

- aged
- blind

- o disabled
- o children under 21 (or at State option under age 20, 19, or 18)
- o specified relatives who have dependent children, as determined under title IV-A of the Act, in their care
- o pregnant women

3581.1 Deeming Methodology for the Optional Hospice Care Eligibility Group.--Deeming refers to the financial eligibility methodology whereby certain amounts of the income and resources of certain persons are considered to be available to the individual applying for or receiving Medicaid whether or not actual contributions are made. In determining eligibility under the new optional hospice care group, States are required to employ eligibility criteria, including institutional deeming rules, that would be employed if the individual were in a medical institution. Thus, States that choose to cover individuals under the new group must use the deeming rules that would be applicable if the individuals were living in a medical institution. In general, when a family is separated due to institutionalization of one (or more) of its members, income and resources (except for actual contributions) are not considered available under the deeming requirements.

3581.2 Effective Date of Eligibility Under the Special Income Level.--Section 1902(a)(10)(A)(ii)(VII) of the Act as amended by §9505(b)(2) of COBRA provides for eligibility to be determined under the special institutional standard in the same manner as if the individuals were in the medical institution. Furthermore, §9510 of COBRA amended the Act at §1902(a)(10)(A)(ii)(V) which concerns the special income level for the optional categorically needy group of individuals actually living in a medical institution. Under §9510 of COBRA, the special institutional standard can only apply to individuals who are living in a medical institution for not less than 30 consecutive days. Where the individuals meet the 30-day requirement, eligibility begins with the first day of the 30-day period.

Under §1902(a)(10)(A)(ii)(VII) of the Act as amended by §9505 of COBRA, the special income level which is applied to individuals living in medical institutions must also be applied in determining optional categorically needy eligibility for hospice care for individuals who are not institutionalized as if they were living in a medical institution. Thus, the requirement for residing in the institution for no less than 30 days must be applied in determining eligibility under the optional hospice group.

By definition, individuals potentially qualifying under the optional hospice care group are not actually living in an institution. Thus, the requirement for 30 days of residence in the institution cannot literally apply to the optional hospice care group. However, in order to be eligible to receive hospice care, individuals must file an election statement with a particular hospice. That hospice will be reimbursed by the Medicaid agency for each day the election for hospice care is in effect, regardless of whether or not the individual actually receives services from the hospice and beginning with the effective date of the hospice election. In applying the 30-day residence requirement to the optional hospice group, the 30-day period begins on the effective date of the election for hospice care. Upon 30 consecutive days elapsing from the effective date of the hospice election, and

where the election is in effect for each of the 30 days, the special institutional standard may be applied to determine eligibility under the optional hospice care group. If the individual's income is within the special income standard, eligibility begins with the effective date of the hospice election.

There may be situations where the 30-day requirement has already been met by an individual. In such cases, the individual electing hospice care does not need to meet the 30-day requirement again in order for the State to apply the special income level. For example, an individual actually living in a medical institution, who has already been determined eligible under the special institutional standard after having been in the institution for 30 consecutive days, may at a certain point elect hospice benefits. As long as there is no break in time between eligibility in the institution and the effective date of the election for hospice care, the agency would not be required to wait for the election to be in effect for 30 consecutive days in order to cover the individual for hospice care.

Similarly, another example occurs where an individual is eligible under the home and community based services waiver group under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217. Individuals under this group live in the community and must also meet a 30 consecutive day requirement for receipt of home and community based care in order to have the special institutional standard apply. Individuals who are eligible under 42 CFR 435.217 for home and community based services may elect hospice care. In such cases, as long as there is no break in time between eligibility under CFR 435.217 and the effective date of the election for hospice care, the agency would not be required to wait for the election to be in effect for 30 consecutive days in order to cover the individual for hospice care.

3582. COMPARABILITY OF HOSPICE CARE BENEFITS

States may choose to provide hospice care benefits to categorically needy individuals only, or to both categorically needy and medically needy individuals. States may not provide hospice care benefits to the medically needy without providing them to the categorically needy (§1902(a)(10)(B)(ii) of the Act).

The amount, duration and scope of hospice care benefits must be the same for all categorically needy individuals. (§1902(a)(10)(B)(i) of the Act.)

The amount, duration and scope of hospice care benefits for categorically needy individuals may not be less than the hospice care benefits for medically needy individuals. (§1902(a)(10)(B)(ii) of the Act.)

The amount, duration and scope of Medicaid hospice care benefits for any eligibility group(s) may not be less than the hospice care benefits provided under Medicare (title XVIII of the Act). (§1902(a)(10)(VI) of the Act as amended by §9505(b)(1) of COBRA.)

3583. COPAYMENTS ON HOSPICE CARE BENEFITS

States may not impose any deductible, cost sharing, or similar charge under the plan to any individuals (categoricaly needy or medically needy) receiving hospice care. (§1916(a)(2) and (b)(2) of the Act as amended by §9505(c)(2) of COBRA.)

3584. POST-ELIGIBILITY TREATMENT OF INCOME FOR HOSPICE CARE

3584.1 General.--Individuals who have elected hospice care benefits may be eligible under either the conventional eligibility groups or under the optional categorically needy hospice care eligibility group under §1902(a)(10)(A)(ii)(VII) of the Act (as amended by COBRA). Rules for post-eligibility treatment of income, i.e., application of an individual's income to the cost of hospice care, apply differently for each of these two groups.

3584.2 Post-Eligibility Treatment of Income for Conventional Eligibility Groups.--Hospice care benefits, as provided under a hospice care program, may be furnished to individuals who are in an institutional as well as noninstitutional setting. Under current Medicaid regulations (42 CFR 435.725, 435.733, 435.832 and 436.832), individuals in medical institutions, after being determined eligible for Medicaid, must have a post-eligibility determination made to apply some of their income to the costs of institutional care. That is, the Medicaid agency must reduce its payment for the costs of institutional services reimbursable by Medicaid by certain amounts of the individual's income. Consistent with the existing post-eligibility provisions for individuals receiving conventional institutional services, post-eligibility provisions must also apply to certain individuals living in medical institutions receiving hospice care benefits which are reimbursable under Medicaid. Post-eligibility provisions apply to those individuals eligible for hospice care if:

-- the individuals are living in a medical institution, and

-- reimbursement under the Medicaid program for hospice care provided to the individuals includes a supplementary payment for room and board provided by the institution.

The post-eligibility process for hospice care patients living in institutions must be the same as applied under the post-eligibility process for individuals in medical institutions (i.e., the rules at 42 CFR 435.725, 435.733, 435,832, and 436.832 apply). In applying the post-eligibility process, the agency must reduce its payment to the hospice for all costs of the hospice care benefits (including the supplementary amounts for room and board) reimbursable under Medicaid by certain amounts of the individuals' income as described in the regulations.

3584.3 Post-Eligibility Treatment of Income for Individuals Receiving Hospice Care Under the Special Institutional Standard.--The committee report accompanying COBRA indicates that it is the Congressional intent that "the rules regarding post-eligibility treatment of income and resources applicable to hospice patients would be identical to those applying to the individuals receiving home and community-based services under a waiver" under §1915(c) of the Act. The post-eligibility process for the special institutional standard hospice care group must be the same as applied under the post-eligibility process for the special institutional standard home and community-based waiver group. (See 42 CFR 435.217.) The rules at 42 CFR 435.726 apply. In applying the post-eligibility process, the agency must reduce its payment to the hospice for all costs of the hospice care benefits reimbursable under Medicaid by certain amounts of the individuals' income as described in the regulations.

3589. MEDICAID COVERAGE OF HOME CARE FOR CERTAIN DISABLED CHILDREN

Under §134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), States are allowed at their option, to make Medicaid benefits available to children (age 18 or under) at home who qualify as disabled individuals under §1614(a) of the Social Security Act provided certain conditions are met, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. The specific statutory provisions establishing this option are contained in §1902(e) of the Social Security Act.

This option is available even if you do not have an approved home and community-based services waiver. You are allowed to make Medicaid coverage available under this option without the burden of seeking approval, on a case-by-case basis, from the Secretary.

In order for a child to establish Medicaid eligibility under this option, determine that:

- if the individual were in a medical institution, he/she would be eligible for medical assistance under the State plan for title XIX;

- the child requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded);

- it is appropriate to provide the care to the child at home; and

- the estimated cost of caring for the child outside of the institution will not exceed the estimated cost of treating the child within the institution.

Children meeting these standards would be eligible for Medicaid even though they were not receiving SSI cash assistance at home. Under the law these children are deemed, for title XIX purposes only, to be receiving SSI, or a State supplemental payment. Of course, 209(b) States which do not provide Medicaid to disabled SSI and State supplement recipients under 19 may not take advantage of this option.

In determining whether the child requires a level of care provided in a hospital, skilled nursing facility or intermediate care facility, determine that the child requires the level of care appropriate to these facilities as defined in 42 CFR 440.10 (hospital), 440.40 (skilled nursing facilites) or 440.150 (intermediate care facilities). If you elect this option you will need to provide coverage to all disabled children who meet the conditions. This is unlike the situation that exists for home and community-based waivers for which the law authorizes a waiver of the statewideness and comparability requirements.

3590. INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A HOME AND COMMUNITY-BASED SERVICES WAIVER

3590.9 Post-Eligibility Treatment of Income and Resources; Application of Patient Income to the Cost of Care.--Reduce payments to providers of services on behalf of individuals eligible for home and community-based waiver services under a special income level. (See 2 CFR 435.231.) The amount by which payments to providers are reduced is the amount remaining after deductions are made for the maintenance needs of the individual, and, if applicable, his spouse and family, from the individual's gross income. In determining the amount by which payments to providers are reduced, deduct from the individual's total income (total income includes amounts deducted from income in determining eligibility) the following amounts, in the following order:

A. Non-209(b) States

1. An amount for the maintenance needs of the individual. This amount must be based on a resonable assessment of the individual's needs, but may otherwise be set at any level you choose. You may establish a different amount for each individual, or for groups of individuals, if you believe that different amounts are justified by the needs of the individuals or groups. However, a maximum amount which will not be exceeded for any individual or group must be established.

2. For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse must be based on a reasonable assessment of need, and may be different for each spouse, but must not exceed the highest of:

o The amount of the income standard used to determine eligibility for SSI for an individual living on his own home, if you provide Medicaid only to individuals receiving SSI,

o The amount of the highest standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if you provide Medicaid to optional State supplement recipients under 42 CFR 435.230, or

o The amount of the medically needy income standard for one person established under 42 CFR 435.811 and 435.814, if you provide Medicaid under the medically needy coverage option.

3. For an individual with a family at home, an additional amount for the maintenance needs of the family must:

o Be based on a reasonable assessment of their financial need, and may be different for each family,

o Be adjusted for the number of family members including the spouse, living in the home, and

o Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard you have established for a family of the same size.

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party includings:

o Medicare and other health insurance premiums, deductibles, or coinsurance charges, and

o Necessary medical or remedial care recognized under State law but not covered under your Medicaid plan, subject to reasonable limits you may establish on amounts of these expenses.

B. 209(b) States.--

1. The amount for the maintenance needs of the individual must be based on reasonable assessment of the individual's needss, but otherwise may be set at any level you choose. You may establish a different amount for each individual, or for groups of individuals, if you believe that different amounts are justified by the needs of the individual or groups. However, you must establish a maximum amount which will not be exceeded for any individual or group.

2. For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse must be based on a reasonable assessment of need, and may be different for each spouse, but must not exceed the higher of:

o The more restrictive income standard established under 42 CFR 435.121, or

o The medically needy standard for an individual.

3. For an individual with a family at home, an additional amount for the maintenance needs o the family must:

o Be based on a reasonable assessment of their financial need, and may be different for each family,

o Be adjusted for the number of family members including the spouse, living in the home, and

o Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard you have established for a family of the same size.

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including:

o Medicare and other health insurance premiums, deductibles, or coinsurance charges, and

o Necessary medical or remedial care recognized under State law but not covered under your Medicaid plan, subject to reasonable limits you may establish on amounts of these expenses.

3596. OPTIONAL COVERAGE OF THE ELDERLY AND DISABLED POOR FOR ALL MEDICAID BENEFITS

Section 9402 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) (P.L.99-509) allows a State, at its option, to make Medicaid benefits available to elderly and disabled individuals with income levels up to 100 percent of the Federal nonfarm poverty guidelines, provided the State has also agreed to cover eligible pregnant women and children established by §9401 or OBRA 86. The specific statutory provisions establishing this option are contained in §§1902(a)(10)(A)(ii)(X) and 1902(m) of the Act.

A. Prior to Enactment of OBRA 86.--Eligibility of the elderly and the disabled for Medicaid was linked to income standards under the Federal Supplemental Security Income (SSI) program, or to higher SSI-related optional State supplementary payments. Those income standards, however, are below the Federal nonfarm poverty guideline amounts.

B. After Enactment of OBRA 86.--Section 9402 adds an optional categorically needy group §1902(a)(10)(A)(ii)(X) of the Act) which consists of the elderly (age 65 or older) and disabled (as defined in 20 CFR 416.900ff (Subpart I)) poor who meet the following financial requirements:

1. Income Standards.--The elderly or disabled individual's income cannot exceed the level you have established. In no event may the level be higher than 100 percent of the official nonfarm income poverty guideline applicable to the individual involved.

Except in 1902(f) States, SSI rules are used in determining what is counted or is not counted as income for this group. (See 20 CFR Subpart K.)

The official nonfarm poverty guidelines are income standards determined by the Department of Health and Human Services and published in the Federal Register annually in or around the month of February.

Costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining if a person's income is less than your selected standard. No spenddown is applied to this optional group. Therefore, there is no comparable medically needy group. Individuals who do not meet the eligibility criteria for this optional categorically needy group must meet the medically needy eligibility criteria or the criteria for other eligibility groups to establish eligibility.

2. Resource Standards.--The elderly or disabled individual's resources cannot exceed the applicable SSI resource standrds, except if you have a medically needy program that has higher standards, you may utilize those higher standards for this group.

SSI rules are used in determining what is counted or is not counted as a resource for this group (see 20 CFR 416.1201).

C. Conditions or States to Utilize This Option and Other Special Rules.--

1. You may not implement this option unless you have also agreed to cover (in the approved State plan) eligible pregnant women (through 60 days following pregancy) and infants up to 1 year of age with family incomes up to 100 percent of the Federal poverty guidelines for a family of the same size, as established by §9401, OBRA 86.

2. Elderly and disabled individuals in this group must receive the same Medicaid benefits provided to the categorically needy under the approved State plan.

3. Elderly and disabled individuals in this group, in addition to meeting the income and resource standards specified above, must meet all other applicable eligibility requirements, e.g.,residency.

4. The different treatment of income and resources provided for the eligible individuals in this group is not applicable for individuals in other eligibility groups, and does not violate the requirements of comparability in §1902(a)(17) of the Act.

3597. TREATMENT OF COUPLES IN MEDICAL INSTITUTIONS

Section 9 of P.L. 99-643 amends §1611(e) of the Act to provide that you may continue to treat a couple (i.e., husband and wife) which has continuously shared a room or comparable accommodation in a hospital, nursing home, skilled nursing facility, or intermediate care facility for a period of 6 months as a couple, rather than as two individuals, even after the end of the 6-month period, if treating the couple as individuals prevents them from being eligible for a variety of programs, including Medicaid. You may treat these couples as couples regardless of any requirements of the SSI program. For purposes of this provision, comparable accommodation means a suite of rooms shared by a couple, or a ward occupied by more than two people in which the couple lives.

3598. COVERAGE OF COBRA CONTINUATION BENEFICIARIES

3598.1 General.--Section 4713(a) of OBRA 1990 amended §1902(a)(10) of the Act to add a new subparagraph (F). This provision allows a State Medicaid program the option of paying COBRA premiums (for which FFP is available) for individuals who are entitled to elect COBRA continuation coverage under a group health plan provided by an employer with 75 or more employees. This new eligibility group is entitled to medical assistance only in the form of COBRA premiums. Premium payments made by the State on the individual's behalf can only occur if such payments are likely to be cost effective.

3598.2 COBRA Continuation Beneficiary.--A COBRA Continuation Beneficiary (CCB) is an individual:

- Who is entitled to elect COBRA continuation coverage;
- Whose income does not exceed 100 percent of the official poverty line as defined by the Executive Office of Management and Budget (EOMB) and revised annually under §673(2) of OBRA 1981 for a family of the same size;
- Whose resources, as determined using SSI rules, do not exceed twice the SSI resource limit; and
- Whom the State has determined that the COBRA premiums paid by the State under this title are likely to be less than the cost of coverage for equivalent Medicaid coverage under its approved State Plan. (See §3598.7 for a discussion of cost effectiveness.)

CCBs must also meet the general non-financial requirements or conditions of eligibility for medical assistance, such as filing of an application for Medicaid, furnishing a Social Security number, proving citizenship and residency, and assigning rights. However, these individuals do not have to meet the categorical requirements of either the SSI or AFDC programs.

In determining income, individuals who are considered functionally disabled under §1612(b)(4)(B)(ii) of the Act may have certain medical and remedial care expenses as described in §1612(b)(4)(B)(ii) excluded from earned income. No other individuals may have medical or remedial care expenses excluded in determining income under this provision.

Use an income standard of 100 percent of the official poverty line and the income methodologies of the SSI program when determining eligibility under this provision.

You may not use more liberal income methodologies under §1902(r)(2) of the Act.

In determining resource eligibility, use the methodologies of the SSI program. You may not use more liberal resource methodologies under §1902(r)(2) of the Act.

3598.3 Eligibility in 209(b) States.--States which have chosen to exercise their option to use more restrictive eligibility criteria than are used by the SSI program may use those criteria in determining eligibility for CCBs under this provision.

3598.4 Definitions.--

COBRA Continuation Coverage--This is coverage under a group health plan provided by an employer with 75 or more employees pursuant to title XXII of the Public Health Service Act, §4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act (ERISA)of 1974.

Type of Benefit Coverage--Coverage must consist of coverage which is identical to the coverage provided under the group health plan to similarly situated beneficiaries with respect to whom a qualifying event has not occurred.

Period of Coverage--Coverage may extend up to 18 months for non-disabled individuals and for 29 months for disabled individuals. In certain situations, the group health plan may extend coverage to the covered employee's spouse and or dependent children up to 36 months. Coverage begins on the date of the qualifying event and does not end before the earliest of the following:

- The date the employer ceases to provide any group health plan to any employee;
- The date the beneficiary fails to make timely payment of any premium required under the plan;
- The date the beneficiary becomes a covered employee under any other group health plan or entitled to benefits under title XVIII of the Act; or
- The date the spouse of a covered employee remarries and becomes covered under a group health plan.

COBRA Premium--For purposes of this provision, the term COBRA premium means the applicable premium imposed with respect to COBRA continuation coverage. Medical assistance is limited to the payment of COBRA premiums.

- Such premium may not exceed 102 percent of the premium otherwise applicable; and

- For months after the 18th month, the disabled individual's maximum premium is 150 percent of the premium otherwise applicable.

Cost Effectiveness--This term means that the amount paid by the State for COBRA premiums is likely to be less than the amount paid for equivalent Medicaid coverage. (See §3598.7)

Group Health Plan--This term means an employee welfare benefit plan that is a group health plan (within the meaning of §5000(b)(1) of the Internal Revenue Code of 1986).

NOTE: COBRA provisions stipulate that the former employer may terminate coverage under the group health plan if the covered employee or his or her family begin coverage under another group health plan. The IRS has determined that military health benefits (including CHAMPUS) available to the families of activated reservists are not a group health plan as defined by IRS code. Therefore, employers may not stop health benefits to reservists called to active duty, or to their families, without their consent. The IRS notice on this ruling appears in Internal Revenue Bulletin 1990-40.

Covered Employee--An individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

Qualified Beneficiary--This term means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan--

- As the spouse of the covered employee, or

- As the dependent child of the employee.

Employment Rule--In the case of a qualifying event resulting from loss of employment, or reduction in hours, the term qualified beneficiary includes the covered employee.

3598.5 State Plan Amendments.--You must in your State plan:

- Provide a methodology for determining the likely cost effectiveness of an individual's enrollment in a group health plan;

- Provide for payment of all premiums under the State plan for recipients enrolled in the plan; and

o Treat the group health plan as a third party resource in accordance with the third party liability requirements in §§3900-3909. However, FFP is available as provided in §3598.8.

3598.6 Individuals Entitled to Elect COBRA Continuation Coverage.--COBRA 1985 (P.L. 99-272) provided that an employer with 20 or more employees that offers a group health plan must offer employees the opportunity to elect continuation coverage under that plan after certain qualifying events, such as termination of employment, or reduction in hours, that ordinarily result in loss of such coverage. Section 4713(a) of OBRA 1990 limits application of this provision to employers with 75 or more employees. The term qualifying event, with respect to any covered employee, means any of the following events which, but for the continuation coverage required under this provision, results in a loss of coverage of a qualified beneficiary:

o Death of the covered employee;

o Termination, or reduction of hours, of the covered employee's employment;

o Divorce or legal separation of the covered employee from the employee's spouse;

o The covered employee becomes entitled to benefits under title XVIII of the Act;

o A dependent child ceases to be a dependent child under the applicable requirements of the plan; or

o An employer who files for Chapter 11 bankruptcy commencing on or after July 1, 1986 (with respect to the employer from whose employment the covered employee retired at anytime).

3598.7 Cost Effectiveness.--Your determination to pay COBRA premiums for an individual enrolled in a group health plan is considered cost effective when the amount you pay for the COBRA premium is likely to be less than the Medicaid expenditures for an equivalent set of services. The methodology for determining cost effectiveness must be included in the State plan and approved by HCFA. Submit documentation demonstrating a reasonable approach to any suggested methodology. Your methodology may include factors not presented in our guidelines, e.g., considering a recipient's diagnosis. The following guidelines are one way to determine cost effectiveness.

Step 1-Policy Information--Obtain information from the individual on all group health plans available to him/her. This information includes the effective date of COBRA coverage, exclusions to enrollment, the covered services under each policy and premiums paid by the employee. If the individual does not have all of the information, contact the employer.

Step 2-Average Medicaid Costs--Using the Medicaid Management Information System (MMIS), obtain the average total annual Medicaid medical costs of persons similar to the applicant (age, sex, category and geographic data).

Step 3-Medicaid Costs for Included Services--Determine the amount of the total yearly Medicaid expenditures that are spent on like services covered by the group health plan policy. Adjust the average medical costs identified in step 2 to take into account this amount. For example, assume that 10 services are covered under the State plan and 6 of those 10 are covered under by the group health plan, but those 6 are the most frequently used services under both the group health plan and the Medicaid State plan. Compute the percentage of expenditures for the group health plan services to the expenditures for the Medicaid services. In this example, assume that the services comprise 82 percent of the Medicaid expenditures which are covered by this group health plan. Then adjust the average total annual Medicaid costs specified in step 2 by this percentage.

Step 4-Administrative Costs--Account for additional costs to Medicaid for processing the group health information by determining the average increase in cost per recipient.

Step 5-Cost Effectiveness Calculation--Compare the costs under the group health plan (step 1) and the administrative costs (step 4) to the costs under Medicaid (step 3). When you make this comparison, compare costs for an equal number of COBRA months to costs for an equal number of Medicaid months.

Savings in Medicaid expenditures are likely if the cost of COBRA premiums you paid is likely to be less than your cost for equivalent services under Medicaid. (See example on determining cost effectiveness.)

Example of Cost Effectiveness Guidelines

Step 1-Policy Information: Obtain information from the individual on all group health plans available to him/her. This information includes the effective date of COBRA continuation coverage, exclusions to enrollment, the covered services under each policy and premiums paid by the employee.

If the individual does not have all of the information, contact the employer.

Individual: Ms.Smith, aged 25, AFDC, county X
Daughter, aged 6, AFDC, county X

Group Health Plan:	One plan available
(COBRA)	Effective date 1/1/91
	No exclusions
	6 Covered Services--Hospital Inpatient, Hospital Outpatient, Physician Services, Clinic, Laboratory and X-ray, and Prescription Drugs.

Premiums: $ 1,600.00 yearly

Step 2-Average Medicaid Costs: Using the Medicaid Management Information System (MMIS), obtain the average total annual Medicaid medical costs of persons similar to the applicant (age, sex, category and geographic data).

MMIS Data:	25 year old female, AFDC, county X =	$1,550.00
	6 year old female, AFDC, county X =	1,250.00
	Total Medicaid Expenses	$2,800.00

Step 3-Medicaid Costs for Included Services: Determine the amount of the total yearly Medicaid expenditures that are spent on the services covered by the individual policy (i.e., the adjusted Medicaid cost).

10 Services offered under the State plan:

--Inpatient Hospital	--EPSDT
--Outpatient Hospital	--Physician Services
--Clinic	--Family Planning Services
--Lab & X-ray	--Physical Therapy
--SNF & Home Health	--Prescription Drugs

6 Services offered under the group health plan (COBRA):

--Inpatient Hospital	--Lab & X-ray
--Outpatient Hospital	--Physician Services
--Clinic	--Prescription Drugs

The services covered by the health plan are the most frequently used services. These 6 services happen to comprise 82 percent of the Medicaid costs in the example State. On an average annual basis, the costs to Medicaid of providing the 6 services offered under the group health (COBRA) are as follows:

Ms. Smith's expenses at 82%	$1,271.00
Daughter's expenses at 82%	1,025.00
Adjusted Medicaid Cost	$2,296.00

Step 4-Administrative Costs: Account for additional administrative costs to Medicaid for processing the group health information by determining the average increase in cost per recipient.

Increased cost to process information	$50.00
Number of recipients	x 2
	$100.00

Step 5-Cost Effectiveness Calculation: Compare the costs under the group health plan (COBRA), Step 1, and the administrative costs, step 4, to the costs under Medicaid (step 3):

Step 1 Group Health Plan Costs	$1,600.00
Step 4 Administrative Costs	100.00
Total Costs To State Under Group Health Plan	$1,700.00

Costs To State For Equivalent Medicaid Services (Step 3)	$2,296.00

Cost effectiveness is likely if the cost to the State under the group health plan is lower than the cost to the State for these services under Medicaid.

Costs to State for Medicaid Services	$2,296.00
Costs to State under group health plan	1,700.00
Savings From Plan	$ 596.00

3598.8 Payment of Premiums for COBRA Continuation Beneficiaries and Federal Financial Participation.--FFP is available for medical assistance to CCBs for COBRA premiums. As described in §3598.2, if you elect to cover this optional group, you are required to cover all CCBs who meet the requirements.

3598.9 Individuals Eligible Both as COBRA Continuation Beneficiaries and Under Other Eligibility Groups Under the State Plan.--An individual who is otherwise eligible for Medicaid under the State plan may also be eligible as a CCB. An individual who is eligible as a CCB and under some other eligibility group may choose, per 42 CFR 435.404, to have eligibility determined only under one category. However, the individual is not required to make such a choice. He/she is entitled to have eligibility determined under all categories for which he/she may qualify. If the individual chooses not to elect COBRA continuation coverage, Medicaid may not pay for any services that would have been paid under the COBRA continuation coverage.

If an individual does not specifically and voluntarily choose to have his/her eligibility determined under one category only, and if he/she is eligible both as a CCB and under another group in the State plan, make the individual eligible both as a CCB and the other group for which he/she is eligible. An individual may meet the eligibility requirements in §3910 related to Medicaid payment of premiums and cost sharing and therefore Medicaid payments are available not only for the premiums but also for coinsurance, deductibles and other cost sharing obligations under the group health plan. If the individual is otherwise eligible under Medicaid, the COBRA continuation coverage constitutes a third party resource which you must pursue under the third party liability procedures in §§3900-3909.

3598.10 Effective Date of Benefits.--The effective date of benefits under this provision is based on the date of application and the date on which all eligibility criteria, including election of COBRA continuation coverage, are met. CCBs are subject to 3 months retroactive eligibility under 42 CFR 435.914. In no case can eligibility as a CCB be effective prior to January 1, 1991.

3598.11 Official Federal Poverty Line.--The official Federal poverty line as defined by EOMB is published annually in the Federal Register by HHS.

3598.12 Determination and Redeterminations of CCB Eligibility.--Determination and redeterminations of CCB eligibility are subject to the rules set forth in 42 CFR 435.911 and 435.916.

3599. BUY-IN TO MEDICAID FOR THE WORKING DISABLED

3599.1 General.--Section 4733 of the Balanced Budget Act of 1997 (BBA) created a new optional categorically needy eligibility group (§1902(a)(10)(A)(ii)(XIII)) to allow States to provide Medicaid to disabled working individuals who, because of relatively high earnings, cannot qualify for Medicaid under existing statute (§1905(q)(2)(B)) under which disabled working individuals may be eligible for medical assistance. If you choose to cover this group, individuals can become eligible for Medicaid if:

- they are in a family whose income is less than 250 percent of the federal poverty level for a family of the size involved; and

- except for their earned income, they would be considered to be receiving SSI benefits.

3599.2 Determining Eligibility.--The eligibility determination for individuals in this group is essentially a sequential two-step process.

- The first step is a net income test, based on the family's combined income, including all earnings. (A family can also be just one individual; i.e., a family of one.) The family's net combined income must be less than 250 percent of the federal poverty level for a family of the size involved. Family income is determined by applying all appropriate SSI disregards and exemptions, including the earned income disregard, to the family's total income. If the family's income, after all deductions and exemptions have been applied, is equal to or exceeds 250 percent of the appropriate poverty level, the individual is not eligible for Medicaid under this provision.

It is up to each State to determine what constitutes a "family" in the context of this provision. For example, you could consider a disabled adult living with his or her parents as a family of one for purposes of meeting the 250 percent family income standard.

- Assuming the individual has met the net family income test, the second step is a determination of whether he or she meets the disability, assets, and unearned income standards to receive an SSI benefit. Income of other family members used in the first step is not included (unless the individual has an ineligible spouse whose income is subject to the SSI deeming rules). To be eligible under this provision, the individual must meet all SSI eligibility criteria (including categorical requirements).

SSI methodologies are used in making this determination except that all earned income received by the individual is disregarded. The individual's countable unearned income (e.g., title II disability benefits) must be less than the SSI income standard, or the standard for optional State supplementary payments (SSP) if the State makes such payments. If unearned income equals or exceeds the SSI/SSP income standard, the individual is not eligible for Medicaid under this provision.

The individual's countable resources must be equal to or less than the SSI resource standard ($2,000 for an individual).

3599.3 Use of §1902(r)(2) and 209(b) Methods.--Under §1902(r)(2) of the Act, States may use more liberal income and resource methodologies than are used by the SSI program in determining eligibility for this group. See §3240ff for additional information on §1902(r)(2). Also, 209(b) States may, but are not required to, apply their more restrictive eligibility policies in determining eligibility for this group. See §3420ff for additional information on 209(b) States.

3599.4 Disability.--There is no requirement that the individual must at one time have been an SSI recipient to be eligible under this provision. However, if the individual was not an SSI recipient, you must do a disability determination to ensure that the individual would meet the eligibility requirements for SSI. A disability determination for an individual who was not previously an SSI recipient should not consider whether the individual engaged in substantial gainful activity (SGA), since use of SGA as an eligibility criterion would in almost all instances result in the individual not being eligible under this group, effectively negating the intent of this provision.

3599.5 Premiums.--You can require individuals eligible for Medicaid under §4733 to pay such premiums or other cost-sharing charges, set on a sliding scale based on income, as you may determine appropriate. The amount of the premium or other cost-sharing to be paid, if any, is entirely within each State's discretion. Section 4733 does not require you to impose a premium or other cost-sharing charges.

3699.6 Benefits.--Medicaid benefits available to individuals eligible under this section are those provided under your State plan to all categorically needy individuals.